Center for Professional Licensing. Medical Marijuana Program
3 Capitol Hill, Room 105A
Providence, RI 02908-5097
401-222-3752 - www.health.ri.gov/hsr/mmp

Practitioner Written Certification Form

Please enter your name, date of birth, and phone number. Ask your practitioner to complete all other sections of this form in order to comply with the requirements of the Rhode Island Medical Marijuana Act. *Please upload this form to your account in the online portal. If you are not using the online portal, attach this form to the* Patient Application Form *and mail the completed forms to the address above.*

NOTE: This does not constitute a prescription for marijuana.

Patient name, date of birth and phone number:

Full Name

Birth Month | Birth Day | Birth Year | Phone

The remainder of this form must be completed by the attending practitioner.

Practitioner name, license number and address

Full Name

License Number

Address (Apartment/Suite/Room Number, etc.)

Address (Number and Street)

City | State | ZIP Code

Phone | Email

These are the **ONLY** approved qualifying debilitating medical conditions - Check the appropriate box(es):

- ☐ Cancer or the treatment of this condition Is the patient receiving chemotherapy? ☐ Yes ☐ No
- ☐ Glaucoma or the treatment of this condition
- ☐ Positive status for (HIV) or the treatment of this condition
- ☐ AIDS or the treatment of this condition
- ☐ Hepatitis C or the treatment of this condition

If yes, practitioner's signature: _____

A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following:
Check all appropriate box(es).

- ☐ Cachexia or wasting syndrome
- ☐ Severe, debilitating chronic pain-(specify) _____
- ☐ Severe nausea
- ☐ Seizures, including but not limited to, those characteristic of epilepsy
- ☐ Severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis (MS) or Crohn's disease
- ☐ Agitation related to Alzheimer's disease
- ☐ Post Tramatic Stress Disorder (PTSD) *(Patient must be 18 or older.)*
- ☐ Autism Spectrum Disorder *(Practitioner must complete Practitioner Written Certification Form for Use with Autism Spectrum Disorder Diagnosis f this diagnosis is checked.)*

I hereby certify that I am a Rhode Island practitioner who is licensed with authority to prescribe drugs pursuant to chapter 37, chapters 34, 37, and 54 of title 5 or a physician licensed with authority to prescribe drugs in Massachusetts or Connecticut. I have a practitioner-patient relationship with the qualifying patient and have completed a full assessment of the patient's medical history, including an initial physical examination. The above-named patient has been diagnosed with a debilitating medical condition as listed above. Marijuana used medically may mitigate the symptoms or effects of this patient's condition. Further, it is my professional opinion that the potential benefits of the medical use of marijuana would likely outweigh the health risks for this patient.

If this patient is eligible for hospice care, the physician must sign here.
Practitioner Signature (patient eligible for Hospice)_____

Practitioner's printed name: _____

Practitioner's signature:_____ Date of signature: _____